



Medicine HYDRAFACIALTM MD Treatment CONSENT FORM

Please read and initial each statement.

I have read the HydraFacialTM Treatment Information and Instructions and have had an opportunity to ask questions about the procedures and treatment. _____

I authorize the laser technician to perform the HydrafacialTM MD on me. _____

The cost of the procedure(s) has been discussed with me and I agree to pay this amount. _____

I understand:

- The goal of HydraFacialTM MD is to deep cleanse and hydrate facial skin with improvement in skin tones and texture, acne breakouts and general skin health. Every individual is unique and it is very difficult to guarantee a specific number of treatments needed. Results vary with the individual and in the case of acne and sun damage depend on the amount of acne and compliance with recommended adjunctive measures and skincare. HydraFacialTM MD treatments are recommended every two to three months for optimal results and anytime before special events.
- Common side effects such as slight redness usually subside within a few hours after treatment.
- Uncommon side effects such as bruising, skin irritation and exacerbation of skin breakout can occur.
- Rarely, allergic reaction, pigment changes of freckles, moles or skin such as hypopigmentation (lightening) or hyperpigmentation (darkening) can occur and may resolve, but can be permanent. Scarring and textural changes are also rare side effects but can result from this procedure. There may be risks not yet known at this time.
- Side effects can worsened with sun exposure and daily use of a good quality SPF is very important and highly recommended.

HydraFacialTM MD treatments are **not recommended** if you are pregnant or breastfeeding, if you have an active infection at the site, if you are taking photosensitizing agents such as those mentioned in the **HydraFacialTM MD Information**

and Treatment Instruction sheet, have an unwillingness to wear SPF products, history of light sensitive seizures and others mentioned in the information sheet. None of these conditions apply to me or if they do I realize I am at increased risk of side effects or complications.

- I will inform the laser technician, nurse or physician if my medical condition changes over the course of treatment.
- The risk of side effects increases with other medical conditions such as immunocompromised conditions (diabetes, HIV, being on immune suppressants such as prednisone) that can be associated with poor skin healing and increased risk of infection. None of these conditions apply to me.
- There are other options for treatment including not having the procedure.
- Every person is unique and although good results are expected, it is impossible to guarantee.
- I should call Salon 297 if I have any questions or concerns about my treatment.

We are here to help you and want your experience to be a pleasant one.

I authorize the taking of clinical photographs for:

- my clinic record
- research and education (discretion applied)
- publication

I have read and understood this HydraFacialTM MD Consent Form. My questions have been answered satisfactorily by the doctor, nurse or laser technician. I accept the risks and complications of the procedure.

Guest name (please print)

Date

Signature

Witness name (please print)

Date

Signature